

COD E-Circular

A Project of the Co-Occurring Disorders (COD) Unit, California State Department of Alcohol and Drug Programs

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COJAC Endorses DDCAT

At its July 2008 meeting the Co-Occurring Joint Action Council (COJAC) decided to recommend the Dual Diagnosis Capability in Addiction Treatment (DDCAT) tool for assessing COD treatment capability.

Details and link in the next COD E-Circular.

Trauma: The Red Thread Connecting Substance Use and Mental Illness

Trauma: Recent research provides extensive evidence on the role trauma plays in the development of COD—that is, both mental illness and substance use issues. Because of its connection to both disorders and its prevalence, trauma is of significant interest among COD populations.

Understanding trauma can help us find opportunities for reducing its impact. This *COD E-Circular* focuses on the interplay of trauma and the social and individual hardships that can lead to it. Trauma can affect anyone, but it has distinct effects on youth, military personnel, women, and older adults.

Throughout California service providers are working to help shape effective county Prevention and Early Intervention (PEI) programs for Mental Health Services Act (MHSA) funding. An examination of the PEI Priority Populations reveals that the youthful populations at high risk for mental illness are those facing the **traumas** of school failure, juvenile justice involvement, or family stress, including domestic or external violence.

Such **traumas** also put these same populations at high risk for substance use problems.

Increasingly, military personnel return from active duty in which violence is both routine and terrifying. The news carries stories about crises in their lives involving substance use and mental illness. Often these issues are connected to veterans' post-traumatic stress disorder (PTSD).

At women's substance use disorder treatment facilities, awareness of **trauma** is critical to successful recovery. Women clients are frequently survivors of domestic violence and/or early sexual abuse, often leading to PTSD. "Trauma-informed" services (see page two) are critical for all PTSD clients, so that treatment does not re-traumatize clients.

Trauma-informed services also increase retention and improve outcomes.

As baby boomers age, awareness is emerging about the impact of the **traumas** of old age. Depression and substance use disorders both find their roots in the **traumas** of grief, social isolation, illness, and the loss of physical capacity. Additionally, the elderly may experience elder abuse, poverty, and homelessness as their retirement incomes fall short of the means to secure a home in a "good neighborhood."

Nationally we also see the terrible, yet predictable, outcomes of the widespread **trauma** of home foreclosures and economic cutbacks. While the news focus may be on dramatic and tragic occurrences, the many lives impacted by substance abuse and mental health issues are largely unseen.

Across the country the aftermath of extreme weather events traumatizes increasing numbers of people. In California, the wildfires throughout the state will have predictable impacts, causing more trauma and more COD.

COD treatment must incorporate awareness of protective factors as well as causes, impacts and effects of **trauma**. This *COD E-Circular* includes resources and references to address the pervasive and powerful effects of trauma on human lives.

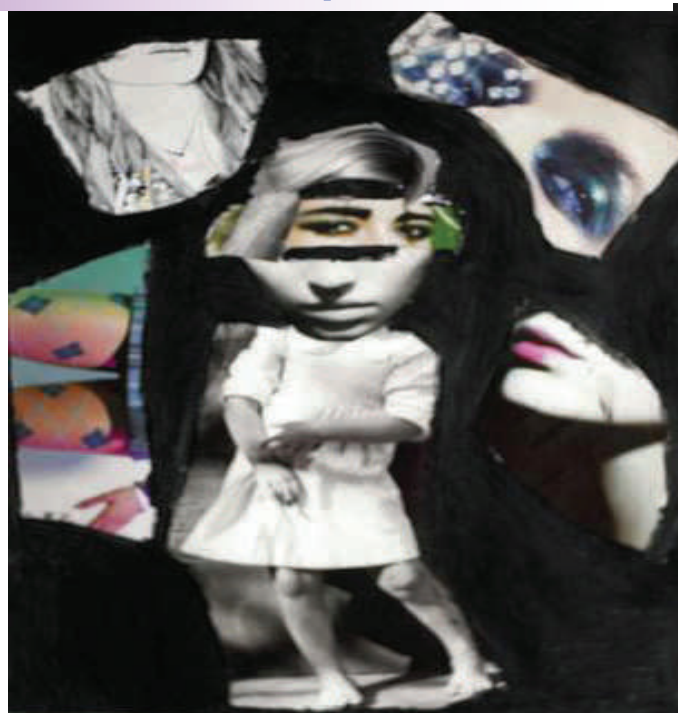
Prevention and Early Intervention and Trauma

In early July, the Department of Mental Health (DMH) provided information about the direction of the MHSA. DMH Information Notice Number 08-17 states, "We ... intend to develop the conceptual design of a three-year plan which integrates the MHSA into the larger public mental health system."¹ While the rest of this Notice goes on to discuss Community Services and Support, the integration of MHSA into California's mental health system has important implications.

(Continued on page 6, **PEI & Trauma**)

The Special Needs of Traumatized Clients: The Varied Faces and Forms of Trauma

Present or past trauma—whether sexual, physical, psychological or emotional—is common in the lives of people with COD. Certain populations are at high risk for trauma. The great majority of COD clients are impacted by past trauma. The following pages present a brief overview of a few key populations, their particular trauma-related concerns, and the importance of empathy when working with those suffering from trauma. When not otherwise stated, citations are from resources on the Substance Abuse and Mental Health Services Administration (SAMHSA) Web site: <http://www.samhsa.gov/>.



Women and Abuse

Incidence—Research has found that between 51 and 97 percent of women with serious mental illnesses report some form of physical or sexual abuse (Goodman et al., 1997). Additionally, women with COD are more likely to experience abuse than those with a mental disorder who are not drug dependent (Alexander, 1996).

Forty-one to 71 percent of women in treatment for drug or alcohol disorders report incidences of sexual abuse as children or adults; and 38 percent are victims of violent crimes (Alexander, 1996). Women who experience any form of sexual abuse as children are three times more likely than other women to report drug dependence as adults (Zickler, 2002).

Associated Mental Illnesses—Overall, sexual or physical abuse is associated with PTSD, anxiety, depression, psychotic symptoms, personality disorders, and correlated with suicidal tendencies, risky sex and drug practices, and substance abuse (Goodman et al., 1997).

Learn about *trauma-informed treatment*:

Get a range of information at SAMHSA's National Center for Trauma-Informed Care (NCTIC):

<http://mentalhealth.samhsa.gov/nctic/trauma.asp>

Additionally, the NCTIC offers free or minimal cost technical assistance and training to publicly funded health/human service systems and programs.

Also, see the link for "Trauma-Informed AOD Treatment for Survivors of Domestic Violence" near the bottom of this webpage:

http://www.adp.ca.gov/TATA_af_am.shtml

October is Domestic Violence Awareness Month

CONFERENCE CORNER

Annual Rose Jenkins Conference Focuses on MHSA & Evidence-Based Practices

How well can you document the outcomes of your treatment services? Are your methods effective? Proven? Do you use evidence-based practices (EBPs)?

If you care about quality treatment, you are thinking about these questions. If you have read about Prevention and Early Intervention funding under the MHSA, you are already familiar with them! And if you attend this conference you will learn about the latest developments in:

- Brief Treatments
- Lessons Learned from EBP Implementation
- Prevention Strategies
- Outcome-Driven Services
- Public Health Approaches
- Co-occurring Mental Health and Substance Use

The conference is in **Sacramento, California, from Thursday, October 23, to Friday, October 24, 2008.** Hotel and registration discounts apply through September 30. For more information and details go to <http://elearning.networkofcare.org/cimh/>.

For additional information on COD-related forums, conferences and trainings, see:

<http://www.adp.ca.gov/COD/conferences.shtml>

Suicide Increasing for War Veterans

Among the most serious issues that military veterans face related to COD is suicide. The causes for the increase in veterans' suicide rates are not well understood. Mental health professionals, however, say the biggest underlying factor is PTSD. Whatever the cause, the cost is high.

Based on U.S. Census data for 2000, of the approximately 25 million veterans in the nation, California is home to the largest population. In California, 2006:

- 666 veterans committed suicide;
- the 2.1 million California veterans represented **only six percent** of the State's 37.1 million residents;
- veterans accounted for **21 percent** of the 3,198 suicides in California (California Department of Public Health statistics).

The sharp rise in suicides appears to be primarily among veterans that served in Iraq and Afghanistan. However, the Veterans Administration (VA) has not disclosed what proportion of suicidal veterans served in Iraq and Afghanistan.

Concerned about the rising suicide rate, veterans groups have sued the VA. The suit seeks an order to force the VA to take stronger action to:

- promptly screen and treat those at risk of suicide,
- set timetables for handling claims for medical benefits.

Testimony in this lawsuit indicates that returning troops are taking their own lives in greater numbers. Expert witnesses and plaintiffs stated there is a steady increase in the veterans' suicide rate since 2001. They claim a comparatively high rate among veterans ages 20 to 24. Witnesses testified the suicide rate for those veterans was anywhere from 2 to 7.5 times the rate among the general population.

A National Institute on Drug Abuse Special Report found high rates of COD and PTSD reported among combat veterans. An inquiry done by the National Association of State Alcohol and Drug Abuse Directors in August 2008 placed California among the 16 states doing the least for returning veterans. The same inquiry found that about half of the states require their providers to screen for, and provide, referrals for clients with potential cognitive disabilities or traumatic brain injuries.

TIP 42 on Empathy*

Empathy is a key skill for the counselor, without which little could be accomplished.... **An empathic style:**

- Communicates respect for and acceptance of clients and their feelings
- Encourages a nonjudgmental, collaborative relationship
- Allows the clinician to be a supportive and knowledgeable consultant
- Compliments and reinforces the client whenever possible
- Listens rather than tells
- Gently persuades, with the understanding that the decision to change is the client's
- Provides support throughout the recovery process

*From SAMHSA's *Treatment Improvement Protocol (TIP) 42, Substance Abuse Treatment for Persons With Co-Occurring Disorders*, Chapter 5: Strategies for Working With Clients With Co-Occurring Disorders, "Use Supportive and Empathic Counseling". Document at <http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstas5.section.74538>

COJAC Shares New COD Screening Tool

This issue of the *COD E-Circular* has a number of articles touching on the fact that individuals exposed to trauma are at increased risk of developing mental illness and/or substance abuse problems. Furthermore, those who work with COD realize that one of the biggest

problems in treatment is inadequate diagnosis. Aware of these two issues, the Co-Occurring Joint Action Council (COJAC) created the new COJAC Screening Tool (CST).

A good COD screening tool identifies those who would most likely benefit from further assessment for mental illness and/or substance abuse.

Screening should be quick and simple. A good COD screening tool identifies those who would most likely benefit from further assessment for mental illness and/or substance abuse. Assessment is a lengthy process, normally performed by appropriately trained staff.

The need for a simple COD screening tool was an early focus for COJAC. COJAC is an advisory body to the Department of Alcohol and Drug Programs and the Department of Mental Health. COJAC members provide comments and assistance on COD

(Cont on page 7, COJAC Screening Tool)

Women, Domestic Violence, and COD

Domestic abuse is a frequent source of trauma for women. It includes physical violence, verbal abuse and emotional abuse. Verbal and emotional abuse can be more devastating than physical violence; however, all abuse is traumatizing. Victims typically conceal abuse for as long as possible.

Few mental health or substance use treatment providers incorporate domestic violence screening. Does yours?

Domestic violence is a high risk factor for mental illness – especially PTSD, substance use disorder, and COD.

Because of these factors, screening for domestic violence among women in COD treatment should be part of intake protocol. However, because of the sensitive and even dangerous nature of domestic violence, special staff training is crucial. Staff should know how to appropriately screen and refer clients

without further traumatizing them. With

Staff should know how to appropriately screen and refer clients without further traumatizing them. With proper training, service providers who incorporate screening improve outcomes.

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A study¹ presented at the International Family Violence Research Conference found that clinic staff adequately trained on screening and responses identified more instances of domestic violence. The women clients appreciated being asked about current and past abuse. In the study, the screened women also felt better able to protect themselves and their children after disclosure of domestic violence to the service workers.

Domestic violence, like alcohol and other drug (AOD) abuse, is a generational issue.² Providing counseling and referrals to help interrupt the cycle can aid future generations, as well as those currently

involved in domestic violence situations.

Simply discussing the problem can be beneficial to those experiencing domestic violence. As stated by the National Center for Trauma-Informed Care, the screening questions for trauma —

...determine whether he or she has experienced violence, abuse, neglect, disaster, terrorism, or war. These questions not only help to obtain the information needed to plan an appropriate safety and recovery plan, but *they also confirm to consumers/survivors that their trauma histories matter*³ [emphasis added].

Although domestic violence may contribute to substance use disorder, substance abuse treatment for survivors and victims does not necessarily stop the violence. In fact, AOD treatment and subsequent abstinence by the victim/survivor of abuse can cause the batterer to feel a loss of control and lead to an increase in violence.⁴

Addressing domestic violence helps contribute to COD recovery. At the same time, service providers should be prepared to respond to the complex and longer-term service needs of the entire family, including the children. According to one authority,

It is increasingly apparent that many of the millions of children who are involved with the child welfare system at any one time have mothers who are victims of domestic violence.⁵

(Continued on page 7, Domestic Violence)



¹Magen, Randy H., Kathryn Conroy, and Alisa Del Tufo, "Domestic Violence in Child Welfare Preventative Services: Results from an Intake Screening Questionnaire," presented at the 5th International Family Violence Research Conference, University of New Hampshire, Durham, New Hampshire, 1997, pages 13-15, (<http://hosting.uaa.alaska.edu/afrhm1/wacan/PPRS.pdf>).

²Center for Substance Abuse Prevention of Substance Abuse's (CSAP's) Prevention Pathways Online Courses, 2003. "It Won't Happen to Me: Alcohol Abuse and Violence against Women" (Fact Sheet). CSAP of SAMHSA, retrieved July 2008, (http://pathwayscourses.samhsa.gov/vawc/vawc_fs_05.htm).

And Women's Health.gov, 2007. "Violence against Women: Domestic and Intimate Partner Violence." [Office on Women's Health in the U.S. Department of Health and Human Services](http://www.4women.gov/violence/types/domestic.cfm), retrieved July 2008, (<http://www.4women.gov/violence/types/domestic.cfm>).

³National Center for Trauma-Informed Care, 2007. Susan Salasin, "Necessary Steps in the Transformation to Trauma-Informed Care." SAMHSA's National Mental Health Information Center, Center for Mental Health Services, retrieved July 2008, (http://mentalhealth.samhsa.gov/nctic/newsletter_08-2007.asp).

⁴Office for the Prevention of Domestic Violence, 1996. Theresa M. Zubretsky and Karla M. Digirolamo, "The False Connection between Adult Domestic Violence and Alcohol." New York State, retrieved July 2008, (http://www.opdv.state.ny.us/health_humsvc/substance/falsecx.html#impact).

⁵National Council of Juvenile and Family Court Judges, 2008. Ann Rosewater, "Building Capacity in Child Welfare Systems: Domestic Violence Specialized Positions". Reno, NV, retrieved July 2008, page 7, (<http://thegreenbook.ncjfcj.org/documents/BuildingCaps.pdf>).

Poverty and Trauma

“Poverty is the worst form of violence.”

Mahatma Gandhi (1869-1948)

Whether or not we agree with Gandhi, it is apparent how poverty creates an environment for many kinds of trauma. Almost any problem can be heightened to the point of trauma when individuals and families lack the resources to respond quickly or sufficiently to needs. Sometimes the connection between poverty and violence is very direct: Low-income neighborhoods are prone to higher crime rates and, in, California's larger urban areas, increased crime frequently extends to gun violence.



Trauma, however, need not be that dramatic to adversely affect lives. Traumatic experiences can occur in various situations that may be connected to lack of financial resources: inadequate or unreliable childcare, family relocations, including evictions or foreclosures, health problems, and general family stress.

In today's economy we are likely to see the incidence of income-related trauma expanding. In a radio discussion in early 2008, Elizabeth Warren of Harvard Law School asserted the following:

A generation ago, one paycheck would buy housing, health insurance, pay taxes, transportation and still have 50 percent left over to spend on all the discretionary expenses. Today, it takes two-thirds of two paychecks to buy those ... and of course, now child care is thrown in. I think families are under a lot more squeeze than they were just a generation ago....47 million people without health insurance, half of all Americans haven't saved a single dollar towards their pension.¹

Poverty can be related to social and racial inequities, which may also lead to other kinds of traumatic experiences. One such trauma is “generational trauma,” in which an historic trauma continues to affect individuals and their reactions to experiences. One example is the near-elimination of Native Americans.

These problems affect more than 1.3 million children who are homeless at some time each year and may result in further trauma.

Complex generational and social interconnections link economics, history, and culture with individual experiences. Such connections underscore the importance of cultural competence and cultural awareness in trauma-informed treatment, as well as in all COD treatment.

When poverty becomes more extreme it can lead to homelessness, which is associated with an entire array of additional problems. According to a project report from the Homelessness and Extreme Poverty Working Group of the National Child Traumatic Stress Network, families now make up 40 percent of the country's homeless population.² The report

goes on to explain:

The experience of homelessness results in a loss of community, routines, possessions, privacy, and security.³ ...The experience of homelessness puts families in situations where they are at greater risk of additional traumatic experiences such as assault, witnessing violence, or abrupt separation.⁴

As the report explains, homeless children are subject to a wide range of additional problems, such as increased illnesses and school failure. These problems affect more than 1.3 million children who are homeless at some time each year⁵ and the negative experiences may result in further traumatization. In an upcoming issue the *COD E-Circular* will focus on the situation of youth, including homeless youth.

Upcoming issues of the COD E-Circular will focus on –

- ✓ ***Foster & Transitional Age Youth***
- ✓ ***Veterans***
- ✓ ***Women***

Subscribe now—free! Just send an email (subject of “E-circular”) to COD@adp.ca.gov.

In your message, please include –

- ✍ your program name,
- ✍ the name of a contact person and
- ✍ the person's phone number and area code.

¹Marketplace, American Public Media, January 11, 2008. “Middle Class Roundtable,” retrieved August 2008, (http://marketplace.publicradio.org/display/web/2008/01/11/middle_class_roundtable).

²Bassuk, Ellen L., MD; and Steven M. Friedman, PhD, “Facts on Trauma and Homeless Children.” National Child Traumatic Stress Network, 2005, retrieved August 2008, page 1, (http://www.nctsn.org/nctsn_assets/pdfs/promising_practices/Facts_on_Trauma_and_Homeless_Children.pdf).

³Ibid.

⁴Op cit, page 2.

⁵Op cit, page 1.

PEI and Trauma *(Continued from page 1)*

With this announcement DMH makes clear that the MHSA is incorporating two key concepts into all of California's public mental health (MH) services. One is the "recovery" paradigm, which supports meaningful lives for all clients. Most alcohol and other drugs service providers are already committed to "recovery" in treatment. The other important concept, emphasized by this announcement, is that the MHSA components and concepts of PEI should be an ongoing part of our public MH system.

Unlike prior DMH funding approaches, PEI programs use MHSA funds for services to individuals who **are not** considered "seriously mentally ill" (SMI). Because many COD clients experience mental illnesses below SMI levels, PEI programs are especially important to those providing COD services. (For a more detailed discussion of PEI and COD, please see the PEI-focused issue of the *COD E-Circular* on the web page, <http://www.adp.ca.gov/COD/documents.shtml>.)

Trauma is a fundamental focus of PEI. Another MHSA document describes the lengthy and inclusive stakeholder-input process for developing the guiding policies for PEI statewide.² It explains,

Out of this comprehensive process came joint policies—based on each organization's principles and ongoing stakeholder input—that emphasize: **PEI Key Community Mental Health Needs...** [and] **PEI Priority Populations.**

The PEI program's "Key Needs" criteria acknowledge the importance of appropriate response to trauma to prevent or minimize later MH and AOD problems.

Under Mental Health Needs there are five "Key Needs":

Psycho-Social Impact of Trauma PEI efforts will reduce the negative psycho-social impact of trauma on all ages." And under Priority Populations, at least four of the six groups involve trauma or likely trauma.

Children/Youth in Stressed Families

Children and youth placed out-of-home or those in families where there is substance abuse or violence, depression or other mental illnesses or lack of caregiving adults (e.g., as a result of a serious health condition or incarceration), rendering the children and youth at high risk of behavioral and emotional problems.

Trauma-Exposed Those who are exposed to traumatic events or prolonged traumatic conditions including grief, loss and isolation, including those who are unlikely to seek help from any traditional mental health service.

Children/Youth at Risk for School Failure

Due to unaddressed emotional and behavioral problems.



Children/Youth at Risk of or Experiencing Juvenile Justice Involvement Those with signs of behavioral/emotional problems who are at risk of or have had any contact with any part of the juvenile justice system, and who cannot be appropriately served through Community Services and Supports.

The PEI program's "Key Needs" criteria acknowledge the importance of appropriate response to trauma to prevent or minimize later MH and AOD problems.³ One article explains the new understanding of trauma in this way:

What we have learned is that it is necessary to serve trauma survivors in an environment that is immediately and directly supportive, comprehensively integrated, and that strives to be empowering for consumers/survivors. We now know that our service systems must be designed, from the first contact, to respond proactively to the special vulnerabilities and "triggers" of past trauma for consumers/survivors.⁴

PEI can help provide funding for programs that incorporate the integration of trauma-informed AOD and MH services called for in this evolving understanding of trauma.

Through October 6, the California Mental Health Directors Assoc. (CMHDA) is seeking applications for membership in the new Social Justice Advisory Committee (SJAC): Visit the SJAC webpage to download the SJAC Membership Application.

¹DMH Information Notice Number 08-17, California DMH, July 9, 2008, page. 1, (<http://www.dmh.ca.gov/DMHDocs/docs/notices08/08-17.pdf>).

²Proposed Guidelines: PEI Component. Enclosure 1, DMH Information Notice #07-19, California DMH, September 23, 2007, pages 4-5, (http://www.dmh.ca.gov/DMHDocs/docs/notices07/07_19_Enclosure1.pdf).

³Ibid.

⁴National Center for Trauma-Informed Care, 2007. Susan Salasin, "Necessary Steps in the Transformation to Trauma-Informed Care". SAMHSA's National Mental Health Information Center, Center for Mental Health Services, retrieved August 2008, (http://mentalhealthsamhsa.gov/ntic/newsletter_08-2007.asp).

Domestic Violence

(Continued from page 4)

In order to reduce the impact of trauma, providers should be prepared to integrate or make referrals for children's services.

One research project found that providing services for children involved in domestic violence allowed greater access to such services for the mothers as well. When women claimed to go for services "mandated" for their children, the women could also access services for themselves. Thus, the strategy of child centered intervention may have lessened the batterer's suspicions of the mother's therapeutic activities.⁶

Providers can improve services greatly by starting with doable steps. Implementing trauma-informed treatment (see link in box, page 2) is key. Developing referral resources and screening procedures can also improve programs' COD capability.

Integration of these services may be challenging, just as integration of COD treatment can be. In COD treatment, providers of mental health and AOD treatment services struggle with making *both* diagnoses the primary diagnosis. Correspondingly, as noted in a 2002 working paper:

Although providers from all three sectors do recognize the convergence of domestic violence, substance abuse, and trauma-related mental health issues, often one issue, depending on the setting, is seen as central, and the others are viewed as secondary problems that will resolve once the primary issue is addressed.⁷

Nonetheless, providers can improve services greatly by starting with doable steps. Implementing **trauma-informed treatment** (see link in box, page 2) is key. Developing referral resources and screening procedures can also improve programs' COD capability.

⁶Op. cit., Magen, page 15.

⁷Domestic Violence and Mental Health Policy Initiative, 2002. Carole Warshaw and Gabriela Moroney, "Mental Health and Domestic Violence: Collaborative Initiatives, Service Models, and Curricula." Domestic Violence and Mental Health Policy Initiative, Chicago, IL, retrieved July 2008, (<http://www.dvmhpi.org/Library.htm#Documents>), page 12.

YOU CAN EMAIL THE COD UNIT AT CODINFO@ADP.CA.GOV

THE COD WEB SITE CARRIES VALUABLE INFORMATION AT [HTTP://WWW.ADP.CA.GOV/COD/](http://www.adp.ca.gov/COD/)

COJAC Screening Tool

(Continued from page 3)

issues to the Department directors. (For further information on COJAC, see the COJAC webpage at <http://www.adp.ca.gov/cojac/> and page 5 of the April 2008 issue of the *COD E-Circular* at <http://www.adp.ca.gov/COD/pdf/Vol%20%201,%20Issue%20%20-%20COD%20E-Circ.-%20Housing.doc>.)

One of the five COJAC subcommittees, the Screening subcommittee, worked diligently to develop a short and easy tool to screen for COD. A key realization of the Screening subcommittee was that an underlying factor in the development of COD, especially for women, is the trauma of sexual abuse and domestic violence. The CST consists of nine questions, including three questions on these often undisclosed intimate violence issues, as well as three questions each on substance use and mental health.

The subcommittee carefully selected questions from other validated and "public domain" (available for public use at no charge) screening tools. The resulting specific sequence and selection of questions is now being scientifically validated.

Validation is the process of testing a tool by administering it to selected populations who, at the same time, complete other validated screening instruments. Generally, the tool being validated is tested on specific age, ethnic, and gender population groups. The tool being tested should successfully predict similar results as the established tool(s). If it does, the validity of the tool is substantiated for the tested groups.

The CST consists of nine questions, including three on intimate violence issues as well as three questions each on substance use and mental health.

If the CST proves valid, the field could benefit from a reliable, user-friendly, simple and short screening tool. It could be used in a wide variety of settings, including at emergency care facilities, criminal justice intake, school counselors' offices and battered women's shelters. Identifying individuals with COD is an important first step towards improving treatment.

COJAC performed pilot tests of the usability of the CST. The pilot tests indicate that the CST is useful in identifying COD in different settings—emergency rooms, etc.—and with different populations.

The CST questions are in the public domain. Some AOD treatment providers are using the CST. You can download the tool and further background information (a slide show) at [http://www.uclaisap.org/slides/psattc/cod/2008/K The Cojac Screener.ppt#478.7.Slide 7](http://www.uclaisap.org/slides/psattc/cod/2008/K%20The%20Cojac%20Screener.ppt#478.7.Slide%207) or at <http://www.adp.ca.gov/cojac/screening.shtml>.